This Issue of the Journal of Urban Health

In this issue, we present a series of articles dealing with violence in urban America. Although some will argue that violence is not a health issue and that the solution to the problem must lie outside the health system, these articles all point out that physicians do have a significant, if not central, role.

The first article, by Dukarm and associates, focuses on pediatricians as identifiers of youth at risk, and their role in preventing or ameliorating that risk. The second article, from the Injury Prevention Program developed by physicians at Harlem Hospital, includes a broad series of interventions from window guards to providing alternative and safe activities for young people, including gardening projects, art programs, Little League baseball, dance clinics, and playground injury prevention. The remarkable finding, in this day when many say "nothing works," is that surveillance data showed a 44% reduction in injuries among the school-age children targeted by the program. Critics will ask what has happened to a comparison group of children during a time when injury rates are declining in most places. Some also will say that it is not the physician's job to develop programs such as art classes. But, much as the major diseases of the past were managed by community attention to safe food and water and public health education, this project demonstrates that creative physicians still can mount successful community-wide programs. Other physicians in other communities need to follow this example and carefully evaluate the outcomes.

The third article on violence is written by Dr. James Sayre, a pediatrician who has worked in the inner city of Rochester, New York, for more than 2 decades and is outraged by the toll that violence has taken on his patient population. He demonstrates the

linkage between the availability of handguns, the interrelation of poverty and unemployment, and possibly television, with the aggressive antisocial behavior seen in our cities. For solutions, he points out that, in addition to the Harlem Hospital Community Program, reported in this issue of the *Bulletin*, a local community project in Newark seems to be bearing fruit. Again, some will say that this is not a problem that physicians can deal with. Clearly, they cannot do so alone, but because the results of injuries and violence come back into the medical care system for treatment and are the major cause of death and disability among young people today, it is clear that physicians need to be involved, as Sayre has been, in dealing with violence.

The fourth article in this series on violence is by Dr. David Satcher, Director of the Centers for Disease Control and Prevention in Atlanta. He too argues that the problems of violence need to be attacked in the same way that medicine has attacked other major killers: by epidemiology and careful evaluation of interventions. He too addresses the issue that we must consider—the role of firearms in violence—and points out that homicides by firearms parallel the increased rate of total homicides, whereas the rate of homicides not involving firearms has remained constant. The well-known Seattle-Vancouver comparison study, which reveals the five-fold higher rate of handgun homicide in Seattle, as well as other studies, show that the presence of a gun in a home increases the risk of suicide almost five-fold, and of homicide, almost three-fold. Satcher also points out some of the promising intervention studies going on. It is reassuring to see that physicians are beginning to attack this overwhelming problem with the same methods they have used to attack more traditional health problems in the past.

Feigelman and colleagues report on the results of a survey that assessed a variety of factors associated with alcohol, cigarette, and drug use among adolescents. Although the sample may not be generalizable to other populations—it was a convenience sample: youths 9 to 15 years of age in nine recreation centers—their study verifies that exposure to drugs, in the family or community, is

related to subsequent use. The earlier that youths began to use any of these agents, the higher is the risk that they will continue to do so. Intervention, therefore, must start early, at least in the junior high school grades, and must involve the family for any successful solution to be had.

Fisher reports on a very interesting New York Academy of Medicine initiative to provide educational opportunities in urban health for medical students in the greater New York area. Despite the problems that have arisen, it is clear that this inter-medical school collaborative effort has made community service easier for participating medical students. As the report concludes, "instilling a strong sense of medicine as a social enterprise should be a goal of medical education."

Home care is becoming a key component of modern health care, whether it be for pregnant women, as reported in the past by Olds and his colleagues, or for broadening the education of medical students, as suggested by Steel and his colleagues in this issue. Remarkably, 95% of the U.S. medical schools completed a survey, and 66 of the 123 reporting medical schools provide some sort of home-visit experience for their medical students. Because a variety of home-visit studies are beginning to show great benefits in terms of patient income, it obviously will become even more important to ensure that medical students learn about this intervention. I cannot resist the temptation, however, to comment that more than 45 years ago, while I was a medical student at Cornell, Dr. Wilson Smillie, professor of preventive medicine there, required all of us to make home visits with a public health nurse during the course of our 3rd year. There is nothing wrong with reinventing the wheel. Indeed, it's a pleasure to see that it is being reinvented.

The final original paper in this issue is the most thought-provoking and challenging of all. Callahan and Parens ask, What are the goals of medicine and what philosophical base do we use to address that central question? It may be difficult for physicians to question their long-held beliefs that what we do must be "good," yet it is clear that we in the developed world have reached

a "third phase" of medicine, where we must ask such basic questions. I urge readers to read this paper thoughtfully, then read it again.

As a policy, the *Bulletin* maintains an interest in the history of medicine. Two reports are included in this issue. The first, the history of the McMahon Clinic, describes an inner-city service developed by a remarkably dedicated small staff. The tragedy is, of course, as one of the fallouts of the Los Angeles riots, this clinic no longer exists. Reading over the article will restore your faith in the dedication and commitment of some physicians today and will go some way to overcoming the prevalent view that physicians no longer have a moral conscience.

As a second historical article, Hookman has reviewed a facet of Sir William Osler's life relating to the inspiration he received from his beloved book, *Religio Medici,* by Sir Thomas Browne. What comes through is Osler's humanitarianism and lack of bigotry, despite Browne's open prejudices.

In our regular Urban Health Data column, the data on homicides in New York City appropriately are related to the articles in this issue on violence, demonstrating a four-fold increase from 1960 to 1990 and the very high percentage of that increase caused by handguns.

From time to time the *Bulletin* will publish reviews of books dealing with issues of urban health. In this issue, we conclude with five book reviews. Likewise, we publish appropriate letters to the editor. Two such letters are published in this issue.

THE EDITOR